DEPARTMENT OF HEALTH AND HUMAN SERVICES

PUBLIC HEALTH SERVICE

# SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

## CENTER FOR MENTAL HEALTH SERVICES

## COOPERATIVE AGREEMENTS FOR COMPREHENSIVE COMMUNITY ACTIONS TO PROMOTE YOUTH VIOLENCE PREVENTION, SUICIDE PREVENTION AND RESILIENCE ENHANCEMENT

**SHORT TITLE: YOUTH VIOLENCE PREVENTION COOPERATIVE AGREEMENTS**

**Guidance for Applicants (GFA) No. SM 00-005**
**Part I - Programmatic Guidance**

Catalog of Federal Domestic Assistance (CFDA) No. 93.230

Under the authority of Section 501 (D) (5) of the Public Health Service Act, as amended (42 USC 290aa), and subject to the availability of funds, the SAMHSA Center for Mental Health Services will accept applications in response to this Guidance for Applicants for the receipt date of May 23, 2000.

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# Part I - PROGRAMMATIC GUIDANCE

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**[Note to Applicants: In order to prepare an application, PART II, @General Policies and Procedures Applicable to all SAMHSA Guidance for Applicants (GFA) Documents@ (February 1999 edition), must be used in conjunction with this document, PART I, AProgrammatic Guidance.@]**

# SECTION I - OVERVIEW

## Purpose

The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) announces the availability of two-year cooperative agreements for community organizations to promote prevention of youth violence and suicide and to enhance healthy youth development. The Youth Violence Prevention Grant Program is designed to complement the much larger *Safe School/Healthy Students Initiative*, a collaborative effort of the Departments of Health and Human Services, Education and Justice. For that program, potential grantees must show evidence of a formal partnership which includes the local educational agency, the local public mental health authority, and the local law enforcement agency. The Youth Violence Prevention Grant Program engages other organizations to address the issues of promoting healthy development, enhancing resilience, and preventing violence and substance abuse through the use of programs which have an evidence base. The goals of this cooperative agreement are (1) to build community-wide understanding of youth violence, (2) to build real and sustainable community-wide, intensive collaborations to address this public health crisis, and (3) to implement and sustain evidence-based youth and family service programs.

SAMHSA is committed to services that are professional, competent and effectively meet the critical substance abuse and mental health needs of the Nation=s diverse population. To be professional, competent and effective, prevention and treatment services must address gender, age, racial/ethnic and cultural issues, and related factors such as geographic and economic environments. Additionally, SAMHSA believes that children, and families must contribute significantly to successful outcomes and must be appropriately involved in the conceptualization, planning, pilot implementation and evaluation of SAMHSA projects.

This Guidance for Applicants (GFA) is a revision of the prior CMHS No. SM 99-009, School Action Grants. This program, hereinafter referred to as Youth Violence Prevention Cooperative Agreements, solicits applications from organizations which will lead/facilitate intensive, community-wide collaborations to address healthy youth development,

enhance youth resilience, and prevent youth violence, suicide, substance abuse and other problem behaviors.

**Phase 1-Community Collaboration Phase-** of the award will be devoted to the development of intensive community-wide collaborations to address youth violence prevention proactively. Specifically, applicant organizations are expected to have the necessary credibility and capacity to lead/facilitate community-wide collaborations to prioritize youth problems to be addressed and to negotiate community agreements (consensus) to plan for the implementation of a proposed evidence-based youth violence prevention program. It is expected that the entire Year 1 of the award will be devoted to the collaboration building process. However, Sites that wish to move into Phase 2 sooner can do so by providing clear documentation that collaboration has been fully achieved and only with prior approval by the Government Project Officer.

**Phase 2-Pilot Implementation Phase-** of the award will be devoted to the piloting of a chosen evidence-based youth violence prevention program. Ideally, strategic collaborations among community organizations have already been achieved and there is consensus that the proposed evidence-based program is the one most likely to result in positive outcomes for youth in the community. It is hoped that community support for the pilot and preliminary evidence of positive outcomes from the pilot would strengthen the local community=s resolve to sustain the program on a permanent basis.

Priority funding consideration will be given to applications proposing services to high-risk, underserved minority children and youth. In addition, under this program projects devoted to youth suicide prevention will receive priority funding consideration. Projects that focus on youth violence prevention and/or resilience enhancement, but which include a suicide prevention component, should apply for the general program and not for the suicide prevention priority. Projects submitted for the youth suicide prevention priority have similar, but somewhat different project requirements (see Appendix B and relevant sections of this GFA).

This cooperative agreement program is one part of SAMHSA=s overall youth violence prevention initiative which also includes the Interdepartmental Safe Schools/Healthy Students

Grants, the Community Prevention Grants and the Center for Substance Abuse Prevention=s Family Strengthening Initiative, which is designed to 1) increase the capacity of local communities to deliver best practices in effective parenting and family programs in order to reduce or prevent substance abuse, 2) document the decision-making processes for the selection and testing of effective interventions in community settings, and 3) determine the impact of the interventions on the target families. Each of the individual grant programs is meant to complement the others by making federal support available to communities in a variety of ways so that each element of the community can make its contribution to promotion of positive youth development and prevention of youth violence.

The cooperative agreement mechanism is being used because substantive involvement of Federal staff is required to facilitate the development of effective and sustained community collaboration and consensus and the implementation of evidenced-based youth and family service programs which will continue to remain viable in communities after Federal funding ends.

**Eligibility**

Applications may be submitted by domestic non-governmental nonprofit and for-profit entities; public or private educational systems, institutions, and agencies; Tribal government units and organizations; and community-based organizations, such as advocacy organizations, community-based health, mental health and social service organizations, parents and teachers associations, consumer and family groups, and minority serving organizations.

This program is related to the Community Prevention Grants (GFA SM00-004) in that similar activities could be supported under that grant or this cooperative agreement; however, the Community Prevention Grants offer support exclusively to States, Tribes, and their political subdivisions. State and local governmental units are not eligible for this cooperative agreement program, with the following exceptions: educational units are eligible to apply for both youth violence and suicide prevention projects and governmental community mental health organizations, can serve as applicant organizations for suicide prevention, but not youth violence prevention projects.

**Availability of Funds**

It is estimated that $4.10 Million per year will be available to support 27 - 40 awards under this GFA. Awards will range from a minimum of $50,000 to a maximum of $150,000 in total costs (direct+indirect) each year of the award. Actual funding levels will depend upon the availability of appropriated funds.

It is expected that of the total number of awards made **four** grants totaling up to $600,000 will be awarded to organizations proposing programs on the prevention of youth suicide. Organizations applying under this priority funding area should indicate this in Box 10 on the face page of the Standard Form 424 together with the designation of the program,AYouth Violence Prevention Cooperative Agreements Suicide Prevention Priority.@

**Period of Support**

Support may be requested for a period of up to 2 years. Annual awards will be made subject to continued availability of funds and progress achieved. Applicants must propose a two-year budget if they want to be considered for 2 years of funding.

## SECTION II - PROGRAM DESCRIPTION

**Supporting Documentation**

The need for an initiative to provide communities with opportunities to implement programs to effectively reduce youth violence, prevent suicide, and promote positive youth development is driven, in part, by the increase in the frequency and severity of youth violence with resulting devastating effects on youths, their families, and communities. In the 90's, violent crimes committed by adolescents increased and the homicide rate for adolescents doubled, with racial/ethnic minority youth at markedly increased risk for violent deaths (Elliott, Hamburg, and Williams, 1998). Youth=s perception of their lack of safety has increased as well. By 1995, 9 percent of students ages 12 to 19 feared they would be attacked or harmed at school and 28 percent of students reported gangs were present in their schools. Violence and the fear of violence in schools and communities interfere with normal learning and arrest or delay

the successful completion of normal developmental tasks of vulnerable children and youth. Suicide is a particularly tragic form of violent death in youth people; in 1997, suicide was the third leading cause of death for persons aged 10 to 24. The suicide rate among Hispanic youth is of concern. Among female high school students, the percentage of high school students who reported attempting suicide is 14.9 percent among Hispanic girls compared to 7.7 percent for the total population of high school students, (Center for Disease Control, Youth Risk Behavior Survey, 1997).

Increases in youth suicide over the past few decades, and survey data that indicate that up to 7 percent of high school youth have attempted suicide, have prompted a number of calls by public health officials to improve efforts to prevent and treat suicidal behaviors in youth. Most recently, the Office of the Surgeon General issued a ACall to Action to Prevent Suicide@([see http://www.sg.gov/library/calltoaction/default.htm and references in appendix B).

Homicide ranks third as the leading cause of death for children 10 to 14 years of age and fourth for children ages 1 to 9. While other causes of death for school-aged children decreased between 1980 and 1995, violent deaths increased by more than 61 percent (Fingerhut et al., 1992; Lowry et al., 1995).Racial/Ethnic minority youth are at markedly increased risk for violent deaths. Among minority youth, especially African Americans, homicide has been the leading cause of death for both males and females between the ages of 15 and 24 for more than ten years(Haskins, Crosby, and Hammett, 1994). Young African American females are *four times* more likely to die by homicide than are non-African American females, whereas young African American males are *eleven times* more likely to die by homicide than are non-African American males, (American Psychological Association, 1993). The rate of increased risk for Hispanic youth is spiraling upward as well (COSSMHO, 1998).

There exists a considerable scientific knowledge base regarding risk and protective factors for youth violence, suicide, and other problem behaviors and the fostering of resilience and the prevention of violence. Experts in the field of prevention have begun to design programs that increase protective processes and/or decrease risk factors for delinquency and other adolescent problem behaviors (see attached Working Paper). This program is designed to provide

communities with the occasion to implement an exemplary practice but first the development of Acommunity will@ or consensus around the proposed practice must be cultivated to maximize the potential for program success and program sustainability. Research findings that have implications for the development and implementation of violence prevention programs include the following:

**$** Preventive interventions should be guided by knowledge of how multiple risk and protective factors interrelate and are causally linked to future violence and how and when they should be addressed through intervention. Violent behavior results from an individual's past history and his/her individual characteristics and dispositions **interacting** with characteristics of the social environment. Risk factors include **neighborhood and community factors**, such as poverty and prevalence of criminal behaviors, **family factors**, such as lack of parental supervision, family violence, and family support of antisocial attitudes and behavior, **school factors**, such as poor achievement and low commitment to school, **interpersonal factors**, such as peer support for antisocial behavior, and **individual factors**, such as a history of aggressive, antisocial, and impulsive behavior and mental health problems. **Risk factors for suicidal behaviors** (thoughts, threats, attempts) include depression and other mood disorders, drug and alcohol use, family problems, and impulsivity (see Appendix B). The risk for problem behaviors tends to escalate with the number of risk factors evidenced by youth. Protective factors that decrease the likelihood of engaging in violence and antisocial behaviors include **individual factors**, such as positive coping with stress and prosocial attitudes, **interpersonal factors**, such as positive attachment to pro-social peers and adults, and **social factors**, such as family, school and community attitudes supporting positive pro-social behaviors and being intolerant of violence and deviant behavior. The most effective interventions are those in which multiple systems that have an impact on children--families, schools, service agencies, the faith community, and other such entities--collaborate to decrease risk factors and enhance protective factors by changing the nature of interactions between the individual and the social context.

- Problem behaviors, such as violence and substance abuse, often co-occur (e.g., delinquency and substance abuse) as do risk factors (e.g., neighborhood poverty and peer support for antisocial behavior) and similar risk factors tend to be associated with varying forms of problem behavior. Therefore, interventions that effectively reduce risk for one type of problem behaviors may also reduce other types of problems behaviors. Often, effective interventions for problem behavior reinforce individual psychosocial competence and prosocial behaviors that compete with the problem behaviors.

- Early age of onset is a particularly potent risk factor for serious and chronic problem behaviors and violent behaviors often show a progression, as offenders tend to add more serious offenses to their behavioral repertoire over time (Elliott, et. al., 1989; Elliott, 1993). Therefore, early interventions that disrupt or delay the development of serious aggressive and antisocial behavior may be a particularly valuable long-term intervention approach (Kellam, et. al., 1998).

- Social-environmental risk factors, such as poverty, lack of economic opportunity, prevalence of crime and social disorganization, are particularly characteristic of some communities with large ethnic minority populations. In addition, many ethnic minority youth experience prejudice and discrimination which can restrict social, educational, and economic opportunities and damage self-confidence and self-esteem. Immigrant and refugee ethnic minority youth also experience additional stress from war-related trauma, forced evacuations or escapes, acculturation and intergenerational conflict resulting from differing levels of acculturation in the family. Major protective factors in many minority groups are the values of communalism, family, and group harmony, which deter violent behaviors by increasing the youth=s social supports both inside and outside the family. In addition, positive appreciation of bicultural youth of his/her family=s cultural heritage can also serve as a protective factor.

- Five percent of Hispanic adolescent males and two percent of Hispanic adolescent girls reported belonging to a gang in the last year. Thirteen percent of Hispanic boys and

ten percent of Hispanic girls reported assaulting another person in the past year. (Synder and Sickmund, 1999). Hispanic adolescent girls have much higher rates of depression, substance abuse, suicidal ideation, and suicide attempts than do adolescents in general. (Centers for Disease Control and Prevention, 1998).

**$** African American youth are arrested for juvenile offenses at twice the rate of their percentage in the youth population and at three times their rate for violent offenses, and they are incarcerated at three times their population rate. (Federal Bureau of Investigation, 1993). On a typical day in 1997, 40 percent of inmates in long-term juvenile detention were African-American youth (Synder and Sickmund, 1999).

**$** Asian American/Pacific Islander and Native American/Native Hawaiian/Native Alaskan youth are two minority populations that experience high levels of risk factors and behavior problems, but have largely been ignored in national efforts in youth violence prevention (Wilson-Brewer and Jacklin, 1991). Factors that might contribute to this relative neglect include: extreme diversity--more than 40 major Asian American and Pacific Islander groups speaking hundreds of languages/dialects as their primary languages and over 500 Federally recognized Indian tribes, these groups: relatively low population percentage compared to other minority groups, their significant linguistic and cultural differences from the majority population, and their significant unfamiliarity with and underutilization of health, mental health, and social services (Sarafica, 1999; Novins, et. al., 1999). Because of the significant linguistic and cultural differences between these populations and the majority culture, significant cultural issues must be addressed in adapting existing youth service programs for these populations. To ensure competent youth service programming for these high-risk and underserved minority youth populations, a priority focus on these populations is required in this GFA.

**$** The Asian American/Pacific Islander populations are noted for their linguistic, cultural and economic diversity, stratified primarily by their acculturation status (i.e., struggling Southeast Asians who have only arrived in the U.S. within the past 25 years vs. 4$^{th}$ generation Japanese

or Chinese Americans). Recent refugees/immigrants from Vietnam, Cambodia, Laos, and Western Samoa experience dramatically high rates of poverty and constantly face language, health/mental health, educational, and political disadvantages, as well as acculturation stress, exploitation and discrimination. Consequently, available data indicates increasing rates of problem behaviors in Asian-American/Pacific Islander youth, such as substance abuse and mental health problems, and antisocial behaviors (Serafica, 1997; Huang, 2000). Communities with significant concentrations of Asian American youth have reported dramatically increased rates of criminal activity, gang membership and arrests for violent crime, especially among Southeast Asians, Chinese, Filipino, and Samoa youth. The dominant culture=s lack of understanding of the severe problems faced by Asian Americans and Pacific Islanders labeling them incorrectly as the model minority have led to this racial group not receiving equitable health, mental health, and other social services. Nationally, Asian American and Pacific Islander communities had rallied to protest this injustice and, in June 1999, President Clinton issued an Executive Order to instruct all Federal agencies to begin to provide equitable services to Asian Americans and Pacific Islanders. AThe Commission shall provide advice to the President, through the Secretary of the Department of Health and Human Services, on: (a) the development, monitoring, and coordination of Federal efforts to improve the quality of life of Asian Americans and Pacific Islanders through increased participation in Federal programs where such persons may be underserved and the collection of data related to Asian American and Pacific Islander populations and sub-populations; (b) ways to increase public-sector, private-sector, and community involvement in improving the health and well-being of Asian Americans and Pacific Islanders; and (c) ways to foster research and data on Asian Americans and Pacific Islanders, including research and data on public health@ (Executive Order, June 7, 1999).

**$** Native American youth experience high rates of poverty, lack of economic opportunity, social isolation in rural reservations or residence in low-income urban areas, and low educational achievement. Native American youth have equal or significantly higher rates of neurodevelopmental problems, mental health problems, suicide, substance

abuse problems, delinquency, and dropping out of school as compared to adolescents as a whole (Manson, et. al., 1997; Beals, et al., 1997; Office of Technology Assessment, 1990). In addition, lack of available culturally competent intervention services, particularly in rural areas, contribute to a lack of youth services for Native American youth (Cross and Deserly, 1995; Novins, et. al., 1999).

## Target Populations

The target populations include pre-school and school-aged children, adolescents, and their families, who are at risk of becoming perpetrators, victims, or witnesses of violence or are at risk for suicide (e.g., youth in gangs or who want to be in gangs or who have made prior suicide attempts), or who are at risk for difficulties in developmentally appropriate functioning (e.g. youth suspended or expelled from school). Target populations can be defined by geographical residence, by community, ethnic, cultural or social identification (e.g., neighborhood, ethnic group, gang group) or by risk status or engagement in problematic youth behavior (e.g., low achieving students, incarcerated youth). The Center, in its award decision making process, will give special consideration to applicants that focus on suicide prevention or on violence prevention/resilience enhancement in especially vulnerable subgroups within the target populations, particularly, Hispanic, Asian American-Pacific Islander, Native American and African American youth, such as Hispanic and Asian American youth at risk of joining gangs or already in gangs, Hispanic American girls at risk for suicide and Asian American-Pacific Islander youth suspended or expelled from school.

## Program Plan

### Goals

The goals of the Program are:

**$** To support community-wide models of collaboration and consensus building to create the necessary changes to provide children/youth with safe environments in which they can grow into competent and resilient adults;

**$** To increase the number of communities using evidence-based programs to address youth violence prevention,

suicide prevention, and resilience enhancement among children and youth;

- **$** To help young people develop the skills and emotional resilience necessary to maintain healthy functioning and engage in pro-social behaviors and to prevent suicide, violent behaviors and alcohol and substance abuse;

- **$** To increase the cultural competence of community-wide collaborations and youth service program implementation in addressing youth problems and youth development; and

- **$** To support collection of evaluation data that will inform other communities about the processes and outcomes of community collaboration and of implementation of effective programs to prevent youth violence and enhance youth resilience.

**Design**

During the award period, sites will be required to:

- **$** Execute a plan to develop intensive community-wide collaboration, especially of critical stakeholders, to address youth violence as a public health threat, achieve consensus on priority areas to be addressed immediately, and support the pilot implementation and sustainability of an evidence-based youth violence/suicide prevention program. Critical stakeholders are defined as those individuals with the authority and resources to ensure successful implementation of a program and to ensure that the program is then institutionalized. Such stakeholders might include representatives of community constituencies that will receive, provide, or support youth and family services, including youth, families, existing youth service providers, faith leaders, cultural brokers, and key decision makers in the community such as local, State, and Federal political leaders, foundations, agency heads, and other leaders able to make funding commitment to support implementation and sustainability of an evidence-based program.

- **$** Select and implement an evidenced-based program on a pilot basis. Three types of evidence are important in assessing the potential value of intervention programs: evidence of program **effectiveness** (i.e., that the program

is likely to change or impact the target of intervention), of program **applicability** (i.e., that the program is likely to be effective with clients from a specific target population), and of program **replicability** (i.e., the program includes procedures to ensure that the program can be implemented so as to maintain fidelity to the types and sequencing of intervention procedures in the original program design in order to provide the greatest chance for program effectiveness).

Evidence of program **effectiveness** includes, in decreasing order of strength, (1) published, well-designed evaluation studies that report relevant client outcome measures, particularly those that document superior outcomes for participants in intervention as compared to non-intervention (control or alternative treatment) groups; (2) a literature review presenting strong empirical evidence that a not-yet-evaluated intervention program targets changeable risk/protective factors or mediating processes that are strongly related to targeted problems using strategies that have been demonstrated likely to alter the risk/protective and/or mediating factors (e.g. a suicide prevention program that targets depressive symptoms in adolescents at high risks for suicide); or (3) model intervention programs designed by program developers with considerable expertise in youth violence prevention/resilience enhancement for which there is consensus among notable researchers that the program might work to reduce youth violence and or youth suicide and the programs have been replicated in a number of sites to provide some evidence of effectiveness based on client satisfaction data.

Evidence of program **applicability** to the community=s targeted youth population may include one or more of the following: (1) demonstrations that the intervention has been effective in well-designed evaluations with multiple populations or in populations similar to the community=s targeted youth population, and/or (2) distinct characteristics of service populations likely to affect the administration or outcome of the intervention, such as age, gender, culture/acculturation,

race/ethnicity, social class, and severity of problem behaviors, were identified and incorporated in the design or subsequent modifications of the program by the original program developers,

Evidence of program **replicability** may include one or more of the following: (1) a clearly written and tested implementation manual that specifies the intervention goals and procedures, (2) training materials and activities to support program implementation (e.g., training courses or training videotapes), (3) availability of technical assistance on implementation from the program developers or from well-trained, experienced implementers, and/or (4) standardized measures of fidelity.

**$** If appropriate, sites are expected to adapt the prevention/intervention program to cultural or other characteristics of the target population and document carefully the needed adaptations

C Develop and execute a plan to sustain the practice on a permanent basis, including a funding source and a process to integrate the practice into the permanent service delivery system. Ideally, this plan should be completed and institutionalized by the end of Year 1.

C Propose a plan to evaluate four aspects of the project: (1) the collaboration/consensus development process; (2) outcomes of the collaboration/consensus process; (3) the process of implementation of the evidence-based program; and (4) the outcomes of the implementation of the evidence-based program. The key requirement is that the results of the evaluation should inform the Federal government and other service organizations of the experiences and outcomes of developing community collaborations and of implementing effective youth services programs.

Sites must make available to the public the results of the activity funded by this cooperative agreement (knowledge transfer). Sites must spend at least 10 percent and no more than 15 percent of their budget on evaluation of the project.

The project should have an experienced, objective evaluator or evaluation team develop and conduct the evaluation plan. The evaluator(s) must have advanced training in a discipline that provides training in research or evaluation and must have considerable experience and expertise in evaluating community-based organizations and interventions in prior Federal grants or comparable projects.

Evaluation of the process and outcomes of collaboration and program implementation should address the following criteria:

**Evaluation of the Process of Collaboration/Consensus Development** should include documentation and/or measurement of the processes used to: (1) **Identify critical stakeholders** (e.g., use of existing collaborations, use of key informants, use of organizational registers) to initiate community-wide collaborations, (2)**Engage** and **maintain the commitment** of these critical stakeholders to the collaboration process, (e.g., provide frequent and timely feedback to decision makers and other constituents of milestones achieved as well as barriers encountered, use of expert facilitators, of Memos of Understanding, formal Letters of Agreement), (3) **Administer** the collaboration (e.g., lead agency, consensus development team, steering committee, topic-specific workgroups); and (4) **Make and implement key decisions** (e.g., delegation or contracting of specific decisions, strategies to resolve stalemates). Documentation should also be made of changes in the structure or functions of the collaboration over time (e.g., new demands on the collaboration, changes in key personnel or in key stakeholders) and of the impact of external social-environmental factors on the collaboration (e.g., legislative and funding changes, community crises).

**Evaluation of the outcomes of the community collaboration**, at the least, should focus on levels of success in (1) Identifying and obtaining commitment of critical stakeholders to participate in the collaboration, (2) Overcoming disagreements/stalemates to achieve meaningful

collaboration, (3) Setting goals and arriving at key decisions by the collaborators, and (4) Achieving stakeholders=, decision makers=, and participating staff=s satisfaction.

**Evaluation of the Process of Program Implementation** should evaluate three aspects of program implementation:(1) fidelity of program implementation - the extent to which the program implementer administers the intervention program with fidelity to the goals, structure, and procedures of the program as designed by the program developers, (2) dosage of intervention received by clients - the extent to which client had an opportunity to be engaged in and/or participated in the intervention procedures of the program, and (3) competence of the program implementer - the extent to which the program implementer administered the intervention procedures in a manner likely to lead to successful client outcomes.

**Evaluation of Program Outcomes**: An assessment of the success of the program in achieving its outcomes should be planned. It is particularly important that the outcome measures chosen (1) measure outcomes that the intervention is designed to impact; (2) are sensitive enough to measure changes in outcomes produced by the program; and (3) are appropriate for the characteristics of the target population, such as age, gender, ethnic and cultural background, and educational level of the program clients. Obtaining definitive outcome data within the expected one year time frame for pilot implementation in Phase 2 of the Project will be difficult. Applicants are expected to obtain only such outcome data as is feasible within this timeframe and reporting such outcome data is expected only in the final report. It is hoped that continued monitoring of longer-term outcome data will continue after termination of federal funding in order to evaluate the impact of the implemented service program and that such outcome evaluation would become institutionalized by community organizations as part of the process of implementing services in the community.

Note: See Appendix B for discussion of evaluation requirements for applications focusing on youth suicide prevention.

**Cooperative Agreement Roles**

This project will involve the cooperation of the Project Sites and CMHS Staff. Government Project Officers and Sites are expected to work closely together to ensure the success of this cooperative agreement program.

**Role of Project Sites**

Project Sites are expected to implement the project plan as detailed in the application and to consult with the Government Project Officer on significant modifications or adaptations of the project plan. The Sites are expected to actively collaborate with the Government Project Officer in ongoing elaboration and adjustment of the project plan, to collaborate and share experience and expertise with other Youth Violence Prevention Cooperative Agreement Sites, and to write up and disseminate descriptions of the project:s collaboration and program implementation experiences and results of project evaluations. The Project Director and Principle Evaluator are required to attend an annual two or three-day national meeting of Sites; travel expenses for the meeting must be included in the budget for Years 1 and 2.

**Role of CMHS Staff**

Substantial CMHS staff involvement in this program will be required to ensure that the Sites meet the program goals. Federal staff will be active participants in all aspects of the cooperative agreement program and will serve as collaborators with Site project directors. The Government Project Officer(s) will have overall responsibility for monitoring the conduct and progress of the Youth Violence Prevention Cooperative Agreements and will make recommendations regarding their continued funding. The Government Project Officer(s) will consult with the Sites and provide technical assistance on collaboration and consensus building models and activities, on appropriateness of youth service programs to address the service needs of community youth and families, on adapting and implementing the service program, on operationalization and implementation of culturally competent practices, and on evaluation design and analysis of evaluation data. Technical assistance may take

the form of directing Sites to published reports, referral to experts, or linking sites with other Site directors with relevant expertise or experience. The Government Project Officer(s) will review quarterly reports and conduct site visits, if warranted or desired. The Government Project Officer(s) will participate in the publication of the results in order to make findings available to the field.

**Project Support Activities**

Grant funds may be used to support direct services only during the Pilot Implementation Phase (Phase 2).[1] Applicants are expected to budget between 10 percent and 15 percent of the total funding amount requested towards evaluation in each year of the project. All sites must budget for project management, evaluation, reporting requirements, and national meetings during both year 1 and 2.

The following are examples of potential activities that may be supported by project funds:

C Expert consultation and training on community needs assessment, collaboration and consensus building models and procedures, the mechanics of the consensus building and collaboration processes, organizational change, service modeling and adapting exemplary practices to unique community requirements;

**$** Logistical support for consensus building and collaborative decision making; obtaining input from and disseminating information to the community-at-large in support of collaboration and consensus building; facilitating the negotiation of agreements between or among agencies and/or service providers; maintaining and strengthening commitment of key stakeholders to the process of adopting evidence-based youth services in the community;

C Education/training and technical assistance regarding identification and review of alternative evidenced-based youth service programs, the pros and cons for adopting a particular program, models for adapting the program; training and technical assistance for staff to support the implementation of the program; and adjustments to the local service delivery system to make the intervention as effective as possible in that community;

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[1]It is expected that the entire Year 1 of the award will be devoted to the collaboration building process. However, Sites that wish to move into Phase 2 sooner can do so by providing clear documentation that collaboration has been fully achieved and only with prior approval by the Government Project Officer.

**$** Travel and other logistical costs necessary to ensure attendance and participation by children, youth and family members, and others needing financial assistance;

**$** Provision of funds to collect the necessary evidence of the effectiveness of the chosen evidenced-based program in order to influence key stakeholders; expert consultation on evaluation design, instrumentation, data gathering, and analysis; disseminating information to stakeholders and/or the community-at-large regarding the impact of the programs on youth outcomes; and

C Identifying a permanent funding source for evidence-based youth services and developing a practical strategy for long-term sustainability of effective youth service programs in the community.

**Measures/Indicators**

Evaluation measures or procedures should be adopted or developed by the applicant organization and used to gather data on four aspects of the project: (1) the collaboration/consensus development process, (2) outcomes of the collaboration/consensus development process, (3) the process of pilot program implementation, and (4) the outcomes achieved by the pilot program implementation.

Although objective evaluation instruments and procedures (e.g., rating scales, standardized coding) are preferred, qualitative data and narrative interpretation are allowable, where appropriate. To the extent that is feasible, evaluation measures or procedures should meet standards for **reliability** (e.g., inter-rater agreement of coding or ratings, test-retest stability), **reliability across populations** (e.g., adequate reliability with different age, gender, ethnic, cultural, and educational groups), **validity** (e.g., valid measurement of the key aspects of an outcome or process construct (face and construct validity), congruence with other valid indicators of a measured construct (convergent validity)) and **validity across populations** (adequate validity in different age, gender, ethnic, cultural, and educational groups). Particular attention should be paid to the adequacy of measurement for ethnic minority individuals and communities and, if such measures or procedures do not exist, evaluation experts and knowledgeable informants from the targeted communities should be engaged to develop or adapt measures. Applicants are urged

to consult with researchers and evaluators with substantive expertise to identify appropriate evaluation measures or procedures.

Documentation of the processes of collaboration and consensus decision-making can include checklists, analysis of meeting process notes, analysis of administrative documents, or interviews of key informants with structured or semi-structured interviews. Results of an evaluation of organization or group process are typically presented as a qualitative analysis of the historical course of the collaboration, focusing on stages of and key events in the development of the collaboration.
Assessment procedures for outcomes of the collaboration and consensus development processes can include rating scales, questionnaires, official records, community surveys, or structured or semi-structured interviews with key decision makers, participants, or constituents. (e.g., indicators might include attendance at meetings, evidence of trust or cooperation among participants, agreement on mission or goals, satisfaction of participants with the collaboration).

Assessments of the process of program implementation can include, but are not limited to:

**$** Fidelity of Program Implementation: Checklists of whether program goals and content (e.g., as specified in a program implementation manual) were followed during intervention sessions; such checklists could be completed by the implementer following intervention sessions or by outside raters using transcripts or tapes of session (either of every session or a sample of sessions); completion by youth of assessment activities included in the intervention program that are indicative of completion of intervention procedures (e.g., activities applying procedures learned in program modules in real world settings)

**$** Dosage of Intervention Received by Clients: Records of the number of sessions attended and continuity of attendance; records of the completion of assignments (e.g., homework assignments) during course of intervention; ratings of engagement of the client in the intervention process during sessions either by the program implementer or by outside raters from transcripts or tapes of sessions; interviews with clients regarding

engagement in the intervention, satisfaction with the intervention procedures, and perceived benefits of the intervention; evidence of client meeting subgoals or sequential goals specified in the program (e.g., in a sequence of goal oriented modules described in the program implementation manual)

- **$** Competence of the Program Implementer: Experience and qualifications of implementer; experience administering the specific or related interventions (especially with the target population); client rating of satisfaction with the intervenor; client interview regarding positive and negative attitudes toward the intervenor; ratings of characteristics of intervenor behavior during sessions (e.g., listening to client=s comments, timing of intervention procedures, empathy and warmth) either by the intervenor following sessions or by outside raters using transcripts or tapes

Several different types of program outcome data could be collected. The most important outcome data that could be obtained would be measures that directly assess reductions in problem behaviors or increases in positive behaviors that are the ultimate targets of intervention programs (e.g., reductions in the frequency or severity of youth antisocial acts or improvements in school achievement). Some problem behaviors that might be the ultimate target of a prevention program occur with low enough frequency that it is difficult to show evidence of a real change in their rate of occurrence (e.g., suicides) and/or are difficult to measure; thus, other indicators of program success (e.g., reduction in rates of depressive symptoms or in suicidal ideation) can be collected as proxy measures. Another appropriate class of outcome measures are measures of *satisfaction* with the intervention. Such data can be collected from youth, their families, their teachers, and program implementers. Measures of program outcomes can include self-report measures; interviews of clients are also commonly used. Checklists and rating scales completed by parents, teachers, peers or clinicians are also used. Behavioral observations in natural or analogue situations are sometimes collected, as are outcomes based on official data (e.g., crime rates, suicide rates, or school suspensions). In general, multiple measures (e.g., self-report inventories, observational measures, structured interviews) from multiple informants (e.g., from youth, their

parents, peers, teachers, and intervenors) are preferred to single source-single measure assessment, if feasible.

## SECTION III - PROJECT REQUIREMENTS

Applicants must provide a Brief Summary (in 5 lines or less, 72 characters per line) of the proposed project for later use in publications, reports to Congress, and press releases. This can be the opening paragraph of the required one-page Project Abstract.

The Project Abstract should include the goals of the project, a description of the community organizations collaborating in the project, and projected number and characteristics (age group, gender, race/ethnicity) of youth and/or their families that will be served in the program implementation phase of the project.

In addition, each application must be accompanied by a project narrative. The narrative should emphasize how the grant proposal meets the Review Criteria of the grant program. If the project is focusing on the priority area of suicide prevention, this focus must be clearly specified in the application to receive consideration for priority funding. The project narrative should observe the following outline and approach, which correspond directly to the review criteria.

### A. PROJECT DESCRIPTION

*STATEMENT OF THE PROBLEM

Provide documentation of the need for violence prevention, suicide prevention, and youth resilience services in the applicant=s community, as well as local resources, and the community=s readiness to collaborate.

The documentation, at a minimum, should include:

**$** Prevalence or perceived seriousness of violence, suicide risk, and other problematic behaviors and/or prevalence of risk factors or lack of opportunities for youth development in the local community (not national data);

- **$** Existing community resources that address these needs including awareness by the community and critical decision makers of the need for youth services, existing community collaborations and/or coalitions, and existing service delivery programs;

- **$** Demographic and social environmental aspects of the community that could impact on the implementation of youth service programs, such as extent to which subpopulations (e.g., ethnic or cultural subgroups) are affected by types of youth problem behaviors in the community, the structure of such communities, such as leaders (e.g., elders, priests or ministers) and organizations (e.g., churches, clubs), and the availability of services and resources that are dedicated to the general population of youth and to the major subpopulations in the community (e.g., language and cultural competence of service providers);

- **$** A description of the extent to which critical stakeholders indicate support for the project. All categories of critical stakeholders--including youth, families, cultural brokers, service organizations, school personnel, law enforcement, school board members, local funders, local politicians-- should be identified and their place in the decision-making explained. A key element of a successful application will be documentation that key decision-makers are willing to engage in discussion of a community response to youth service needs (e.g., Formal Letters of Agreements detailing roles and responsibilities of each participating organization/group, and other related documentation, which should be included in Appendix 2 of the application).

*TARGET POPULATIONS

Identify the specific population or subpopulation(s) that will be the target of the proposed project. This could be the general population of youth in the community, specific underserved subpopulations (e.g., ethnic or subcultural groups) or subpopulations defined by risk or need status (e.g., youth with arrest records or school dropouts). It is important for the applicant organization to have a clear understanding of the demographics and risk profiles of the

target population(s). A profile of the target community should be provided including:

- **$** Demographics of the target population, including numbers and percentages of major racial/ethnic groups, number and percentages of groups with limited English proficiency, amount of economic and educational disadvantage in the community, and family structures;

- **$** Languages spoken and read by the target communities and proficiency in these languages. If there is a sub-population that is non-English speaking or limited-English speaking, what languages are primarily spoken?

- **$** Specification of the criteria used to define high-risk status and the prevalence of high-risk groups, such as youth with prior arrests, with significant depressive symptomatology, or youth living in families with domestic violence. Procedures to identify high-risk groups should be explicitly described with appropriate inclusion and exclusion criteria for program recruitment (for discussion of risks for suicide, see Appendix B).

*PURPOSE AND GOALS

The application must specify:

- **$** Problem behaviors or risk and resilience factors that are the potential intervention targets for the project based on a likely community consensus that service programs are needed and can be implemented in the community

- **$** The approach to be taken with an evidence-based service program to affect change in the intervention target(s) (e.g., school-based services, family support interventions)

- **$** The expected impact of the project on the intervention targets (e.g., number of youth served, reduction in problem behaviors in the community)

- **$** The overall goals of the collaboration process (e.g., degree of commitment to the collaboration expected, long-term sustainability of the collaboration)

- **$** The overall goals of the project evaluation (e.g,, how the evaluation will be used to improve service delivery or expand youth services)

- **$** How the project will improve the cultural competence of collaborations and of youth services with respect to the cultural diversity of the community

- **$** The expected sustainability of the collaboration and of youth violence prevention, suicide prevention, or resilience enhancement services after the termination of federal support

- **$** The expected impact of the project on the community as a whole and to major subgroups within the community (e.g., usefulness of the collaboration, youth service programs, and the evaluation)

B. PROJECT PLAN

*DESIGN

The description of the Project design should include three components: (1) a plan for community collaboration and consensus development, (2) selection of and plan to implement an evidenced- based family and/or youth service program, and (3) discussion of procedures to ensure cultural competence of the Project.

**1. Plan for Intensive Community Collaboration and Consensus Development**

**For Youth Violence Projects:** The application should describe a detailed plan to initiate and sustain a community collaboration process aimed at achieving consensus among critical stakeholders on ways to address the local community=s youth problem behaviors, especially youth violence and youth suicide, and to enhance youth positive development. Such a plan should be based on a review of both existing conceptualizations and research on models of community collaboration and consensus development and on prior experiences in the community. Both the literature review and the lessons learned from the local community should be documented in the application.

The plan to develop community collaboration should include, at a minimum, the following elements:

- **$** Procedures to identify and engage critical community stakeholders whose participation is likely to effect the success of the implementation of the service program (in addition to those already committed to the collaboration).

- **$** Discussion of the administrative structure and operational procedures of the proposed collaboration with indications that such structure and operational procedures are likely to be accepted by critical community stakeholders. These administrative characteristics should be based on research evidence of what works in similar communities, on prior experience with collaboration structures in the community, and on consideration of unique characteristics of the applicant=s community.

- **$** Discussion of strategies for achieving consensus among stakeholders, including management of the negotiation process and procedures to increase commitment to the collaborative process among stakeholders. Describe potential barriers and strategies to overcome them. Contextual issues such as characteristics of the existing service delivery system, funding sources and limitations, potential liability issues, legislative mandates, and indicators of community readiness to change and to collaborate, should be discussed. Resources that can be recruited to enhance the collaboration process should be identified (e.g., consultants on collaboration models or facilitators of consensus processes).

- **$** If the Project is primarily focusing on an ethnic/cultural minority group or has substantial representation of ethnic/minority youth and families in the target population, describe how individuals from the target ethnic/cultural minority group are involved in the development of the application, of the plans for project collaboration, choice of service program(s) to be implemented, implementation plan, evaluation plan, and dissemination and use of evaluation information.

- **$** Description of how the partnership will be essential in ensuring sustainability of activities when Federal funding ends.

**For suicide prevention projects:** The plan should include, at a minimum:

- **$** Identification and engagement of critical community stakeholders that are relevant to the chosen exemplary suicide prevention program

- **$** Discussion of the inclusive collaborative structure that will direct the activities of the partnership

- **$** Description of potential barriers to successful partnership among stakeholders and strategies to overcome them

- **$** Description of how the partnership will be essential in ensuring sustainability of activities when Federal funding ends.

**2. Selection and Implementation Plan of the Proposed Evidenced-based Program**

**Selection of an Evidence-Based Program:**

Applicants must carefully select and propose up front, with concise description, an evidenced-based youth or family service program that it proposes to achieve consensus to pilot and sustain. **The application should address the extent to which the chosen program meets each of the three criteria of program effectiveness, applicability/adaptability, and replicability as discussed in the Section II-Program Description of this GFA.**

Program developers often can provide some of the evidence for the effectiveness, adaptability, and replicability of their programs. However, such materials should be viewed critically as they might be biased. Therefore, other independent sources of information on the evaluation or implementation of the program, such as published research and evaluation reports, should also be sought. A Working Paper on youth resilience enhancement/violence prevention and a Matrix of promising and evidence-based youth violence prevention programs are provided as references. However, SAMHSA does not endorse any particular program cited in these resources; the applicants are fully

expected to research their chosen program thoroughly to provide the required documentation.

Documentation of the extent to which the selected program meet evidentiary criteria should include:

- **$** A detailed review of the research and evaluation evidence for claiming that the proposed service program is likely to be an effective intervention for identified local youth needs, addressing both the empirical evidence supporting the proposed practice and the extent of consensus among experts on the subject

- **$** A discussion of the research and evaluation evidence for claiming that the chosen service program is likely to be applicable or adaptable to the applicant=s specific target group(s). The discussion should include a description of the replication(s) of the proposed service program(s), including descriptions of the communities where the practice has been replicated. Particular attention should be given to describing why the practice is likely to be effective for the target population that exist in the applicant=s community.

- **$** A discussion of the basis for claiming that the evidence-based practice can be effectively replicated with fidelity by the applicant. If feasible, the manual should be included as an appendix to the application;

**Implementation Plan of the Proposed Evidence-Based Program:**

Note: Projects may only use funds for direct services during Phase 2 and only after the Project has convinced the Government Project Officer that community collaboration has been firmly established and consensus to pilot an evidence-based program has been achieved.

The applicant must submit a work plan that describes the processes and milestones for implementing the selected evidenced-based program. Sites are strongly encouraged to respect and maintain fidelity to the original model; however, if adaptations to the proposed model are needed to better address local youth characteristics and needs, the procedures to be used to adapt and test the proposed model should be clearly documented. The following information should be included:

C A description of the specific activities to be taken by the collaboration to obtain community consensus in support of the piloting and the sustainment of a candidate evidence-based program;

C A description of the specific activities that will be employed to carry out a pilot implementation of a chosen evidenced-based program with fidelity in the local setting;

C If adaptations to the original program are anticipated to better address the needs of the local population, the applicant organization is expected to consult with the original program developer(s) about these adaptations and document them in the application. Applicants must also provide clear and convincing argument for adaptations as well as specify specific components of the original model that will be adapted, and by whom.

C A discussion of the potential barriers to pilot implementation and how they will be overcome.

## 3. Procedures to Ensure Cultural Competence of the Project

The collaboration process, the evidence-based program selected for implementation, and the implementation process *must* be compatible with the values, norms, and life circumstances of the racial/ethnic groups that are being targeted for intervention. Projects that target specific ethnic/cultural groups or in communities with substantial ethnic/cultural diversity must account for this diversity in all phases of the project plan. Projects in communities with less ethnic/cultural diversity must nevertheless ensure that all ethnic/cultural groups in the community have access to the proposed services and that such services are delivered in a culturally competent manner. The application should indicate if adequate consideration has been given to the following issues:

Service Planning and Implementation:

**$** Describe the approach of the project in addressing the diversity of the service community that is indicated in the demographics. What outreach methods are used to

recruit collaboration participants and youth and families from various ethnic/cultural groups in the community?

- **$** Are all languages of the service community available at all points of contact?

- **$** Describe whether consideration has been or will be given to incorporating well-recognized and evidence-based alternative modes of intervention widely accepted in major cultural groups in the community;

- **$** Describe how culturally diverse youth, families, and community leaders are involved in the project. Is there a minority youth or a family organization involved? Are culturally diverse youth, family members, and community leaders involved in developing policy, in developing service plans, in deciding how to spend money, in data collection, in informing policy makers about the services needed?

- **$** Are culturally diverse family members hired as project staff and at what levels?

- **$** Are culturally diverse youth, family members, and community leaders represented on all standing committees, steering committees, and advisory boards of the project?

- **$** How do the key collaborating organizations= written policies and plans reflect inclusion of the cultural values of the service community?

- **$** With non-English speaking or limited-English speaking youth and families, what provisions are made to ensure their full and equal participation?

- **$** Is support being provided to youth and family members to allow them to participate in the project, such as providing transportation, child care, and compensation for taking time off from work?

- **$** Is the physical environment of the service site(s) appealing to the culturally diverse youth and families? For example, are there signs, posters, and magazines in the languages of the service community?

Information:

- **$** Describe the extent to which information provided to youth and families, including consent forms and satisfaction surveys, are available in languages and at reading levels understood by them.

- **$** Describe plans to provide feedback to community stakeholders and constituencies on the process and outcomes of the collaborative and implementation processes in a linguistic and culturally appropriate manner.

Human Resources:

- **$** Are staff at all levels of the project organization proficient in the languages and cultures of the target population?

- **$** Will staff at all levels of the project organization receive cultural competence training specific to the target community?

- **$** Describe the number of trained translators and interpreters available.

- **$** Will interpreters and translators receive specific training in violence prevention, suicide prevention, resilience enhancement issues and terminology?

Outcomes:

- **$** Describe plans to assess youth/family satisfaction with services in a culturally competent manner (e.g. anonymous surveys and/or peer group discussions).

- **$** Describe plans to keep track of attendance and drop-out rates by racial/ethnic groups.

*EVALUATION:

The application must contain a description of a plan to evaluate four aspects of the project as discussed in Section II-Program Description of this GFA:

- **$** The process of community collaboration and consensus development
- **$** Outcomes of the collaboration and consensus development

**$** The process of program implementation
**$** Outcomes of program implementation

The qualifications and experience of the evaluator(s), particularly in evaluating community-wide prevention programs, community collaborations, and youth services, should be described in the application and curriculum vitae should be attached.

The discussion of the evaluation plan should include a description of the design of each of the evaluations (e.g., if pre-intervention and post-intervention measures will be collected, if control or comparison groups will be used), what type of data will be collected for each aspect of the evaluations (as described in the evaluation section in Section II - Design of this GFA), the schedule for data collection, who will collect the data and how it will be analyzed, and a plan to provide timely feedback from the evaluation to the collaborators and the community.

*DATA COLLECTION AND ANALYSES

For each of the evaluations of collaboration process and outcome and of program implementation process and outcome the applicant should specify:

**$** The quantitative and qualitative data which will be collected, the instruments or data collection procedures to be used, any adaptations/modifications to instruments or procedures for special target populations,

**$** Any evidence for the reliability and validity of key evaluation measures (e.g., published reports, data reported by the measure developers) or procedures to ensure reliability and validity of key evaluation measures (e.g., procedures to ensure inter-rater agreement for ratings, cross validation of interpretation of qualitative data),

**$** How the evaluation measures will be summarized and reported,
**$** How the evaluation measures and procedures will meet the needs of and be understandable to critical stakeholders participating in the collaboration.

C. PROJECT MANAGEMENT

The Management/Staffing plan of the project should be clearly specified. In particular, the application should include the following:

C A description of the qualifications and relevant experience of the project director and other key personnel with youth/family service programs and with delivering services to the community=s targeted ethnic/racial/age groups. Biographical sketches and curriculum vitae are required. Describe if the key staff reflect the racial/ethnic make-up of the target population(s) to be served;

**$** A description of the qualifications and experience of key staff for the evaluation component of the project. Biographical sketches and curriculum vitae, if available, should be attached. Describe if the evaluators reflect the racial/ethnic make-up of the target population(s) to be served;

C A description of the capability and experience of the applicant organization(s) with similar projects and populations;

C A description of the relevant experiences, capability and commitment of proposed collaborators, consultants, and subcontractors (letters of commitment should be included in Appendix 2 and detail the extent of involvement in tasks related to this grant proposal);

**$** A description of prior collaborations in the community or among participating organizations;

C A description of the project management plan including time lines, key activities or milestones and deadlines for accomplishment, individual or organizations responsible for key activities and staffing patterns for the collaboration and program implementation phases of the project (e.g., rationale for percent of time for key personnel and consultants - with attention to cultural, age, language, and gender issues);

C A description of the relevant resources available (e.g., computer facilities, volunteer manpower) through the prospective grantee;

- **$** A description of relevant resources (e.g., consultants, equipment, logistical support) that need to be recruited or purchased to support the collaboration and implementation plans; and

- C A description of the applicant=s strategy to sustain the evidenced-based programs and practical strategy for increasing the probability of long-term service delivery.

POST AWARD REQUIREMENTS

Financial status reports will be required as specified in the PHS Grants Policy Statement requirements and the applicant will be informed of the specific requirement when the cooperative agreement is awarded. In addition, programmatic interim and final progress reports will be required and will be specified by CMHS staff after award of the cooperative agreements. In accepting the award, the grantee agrees to provide SAMHSA with OMB approved GPRA program evaluation data. The Project Director and Principle Evaluator are required to attend an annual two or three-day national meeting of Sites (most likely in the Washington D.C. metropolitan area); travel expenses for the meeting must be included in the budget for Years 1 and 2.

The Government Performance and Results Act of 1993 (GPRA) requires federal agencies to set and monitor performance standards for agency objectives. As part of GPRA reporting requirements, CMHS may require grantees to report information relevant to the CMHS GPRA program goals described in Appendix A. For example, CMHS might require grantees to indicate whether this cooperative agreement program helped communities to identify service needs and improve availability of services.

## SECTION IV - REVIEW of APPLICATIONS

### Guidelines

Applications submitted in response to this GFA will be reviewed for scientific/technical merit in accordance with established PHS/SAMHSA review procedures outlined in the Review Process section of Part II. Applicants must review the Special Considerations/Requirements and Application Procedures sections that follow, as well as the guidance provided in Part II, before completing the application.

**The review criteria A-C below correspond to subsections A-C in Section III above to assist in the application process. Reviewers will respond to each review criterion on the basis of the information provided in Section III by the applicants. Therefore, it is important for applicants to follow carefully the outline, headings, and subheadings when providing the requested information.**

Applications will be reviewed and evaluated according to the review criteria that follow. The points noted for each criterion indicate the maximum number of points the reviewers may assign to that criterion if the application is considered to have sufficient merit for scoring. The assigned points will be used to calculate a raw score that will be converted to the official CMHS priority score.

**Review Criteria:**

A. PROJECT DESCRIPTION (10 Points)

*STATEMENT OF THE PROBLEM:

**$** Adequacy of documentation and description of seriousness of violence/suicide and other problematic behaviors and of risk factors or lack of opportunities for positive youth development in the local community, based on community surveys, official data or records describing the community (i.e. census data, clinic summary data, or arrest records, focus groups or interviews with key decision makers or opinion leaders);

**$** Adequacy of documentation and description of the social environment of the community, including available services, service needs, existing community collaborations and/or coalitions, community awareness of the need for youth services;

**$** Documentation of the extent to which critical stakeholders indicate willingness to collaborate to address needs of youth in the community (Memos of Understanding must be included in Appendix 2 of the application).

*TARGET POPULATION:

**$** Adequacy of the rationale for targeting particular group(s) of children/youth for services in the pilot implementation phase. If certain groups of eligible children/youth are excluded, justification for their exclusion must be provided.

**$** Adequacy of documentation and description of the characteristics of children/youth in the target population (e.g., race/ethnicity, age, gender, languages spoken, school dropout rates).

*PURPOSE AND GOALS:

Extent to which the application:

**$** Clearly specifies risk and resilience factors or problem behaviors that will be potential intervention targets and the extent to which goals, objectives, and activities of

the collaboration are based on assessment of needs of community youth, the social environmental characteristics of the community, and available or needed community resources;

- **$** Provides indications that there exists a likely community consensus that service programs targeted to the indicated risk/protective factors are needed and can be implemented in the community;

- **$** Provides a preliminary list of goals, objectives, and activities for which it is necessary for the critical community stakeholders to achieve consensus in order for services to be adopted;

- **$** Explicitly identifies and describes a candidate evidenced-based youth or family service delivery program to address the identified intervention targets and the extent to which selected program is relevant to the needs or risks of targeted community youth;

- **$** Describes the role of evaluation in the project and how results of the evaluation will be used and disseminated.

B. PROJECT PLAN (80 Points)

DESIGN (55 Points)

1. Plan for Intensive Community Collaboration (15 Points)

The following three criteria will be used to evaluate the plan to develop a community collaboration and achieve a community consensus on implementing youth service program:

*Engagement of stakeholders in the collaboration:

- **$** Extent to which critical community constituencies and organization necessary for implementing youth service programs have been identified;

- **$** Extent to which children, youth and families as client stakeholders will participate in the collaboration; and

- **$** Accommodation of the collaboration to the cultural diversity of stakeholders.

*Adequacy of plan to initiate and sustain a community collaboration to achieve consensus on addressing youth problems and promoting youth development:

**$** Adequacy of review of research on existing conceptualizations and models of collaboration and community consensus;

**$** Documentation of prior collaboration experiences in the community; and

**$** Amount of detail presented and clarity of plan for community collaboration and consensus development.

*Adequacy of description of administrative structure and functioning of collaboration:

**$** Feasibility of achieving goals and objectives of the collaboration;

**$** Adequacy of specification of administrative structure, operational, and decision-making procedures of the proposed collaboration, especially as based on existing models or community experience; and

**$** Adequacy of discussion of strategies for achieving consensus among key stakeholders and plans to recruit resources to facilitate collaboration.

2. Selection and Implementation Plan of the Proposed Evidenced-based Program (20 Points). This section has 2 parts:

*Evidence of the effectiveness of the proposed program in addressing community youth needs, applicability of the program in the community, and ability to implement the program with fidelity:

**$** Strength of the research and evaluation evidence that the intervention is likely to be effective in addressing problem behaviors or risk and protective factors of community youth, especially based on well designed studies of client outcomes; quality of review of published and unpublished studies; number of well designed studies indicating success of program;

**$** Strength of evidence that the program will be applicable or adaptable to the community youth population, such as extent to which the intervention program has been demonstrated to be effective in evaluations with multiple populations or in populations similar to the community=s targeted youth population and/or extent to which the intervention program has been developed with consideration of variability in characteristics of clients, such as age, gender, ethnicity, and risk status and incorporates appropriate and possibly distinct interventions targeted toward client differences;

**$** Strength of evidence that the program can be implemented with fidelity, such as the existence of a clearly written and tested implementation manual; availability of training materials and/or technical assistance on implementation; and/or proposed use of standardized measures of fidelity.

*Adequacy of Plan to Implement Selected Evidence-Based Program :

C Extent of involvement of critical stakeholders, including youth and family, in the implementation plan;

C Degree of detail and likely effectiveness of specific activities that will be employed to carry out a pilot implementation of the selected program;

**$** Adequacy of description of details of the implementation, including who will implement, characteristics and number of youth who will participate in the pilot implementation and time lines for implementation;

**$** If adaptations are required, adequacy of the plan to adapt the selected program to meet the unique characteristics of the community and its youth; and

C Identification of potential barriers to pilot implementation and feasibility of plans to overcome them

3. Procedures to Ensure Cultural Competence of the Project (20 Points)

Extent to which application incorporates considerations of cultural diversity into all or most aspects of the needs and

resource assessment, collaborative process, selection of program, implementation and evaluation of the program, including:

- **$** Description of the cultural, ethnic and linguistic demographics of the community;

- **$** Participation of representatives of the major cultural and ethnic groups in the community in all phases of the collaboration and implementation process;

- **$** Accommodation of the collaboration and intervention process to linguistic and cultural differences in the population;

- **$** Project staffing reflects cultural diversity in the community and provides the project with the competence to implement the intervention with the major cultural groups in the target population;

- **$** Relevance of outcomes of the intervention program(s) to the major cultural groups receiving the programs; and

- **$** Dissemination of information on collaboration, implementation, and outcomes of the intervention are conveyed to major cultural groups in the community in a linguistically appropriate and culturally sensitive manner.

EVALUATION (15 Points)

- **$** Adequacy of plan to collect evaluation data as specified in Section III for the:

    Collaboration and consensus development process
    Collaboration and consensus development outcomes
    Program implementation process
    Program outcomes

- **$** Adequacy of description and details provided of the evaluation procedures, including when evaluation data will be collected, what type of data will be collected, who will collect it, what are the primary evaluation questions to be addressed, who will analyze the evaluation data; and

- **$** Qualification and experience of the evaluator(s).

DATA COLLECTION AND ANALYSIS (10 Points)

- **$** Use of valid and reliable evaluation measures;
- **$** Extent to which measures adequately capture relevant processes and outcomes;
- **$** Extent to which outcome measures can assess change in targets of intervention;
- **$** Use of standardized data collection procedures;
- **$** Plan to analyze and report evaluation data that will inform the project staff and the community and will inform the services and evaluation communities; and
- **$** Usefulness of data collected and its reporting to stakeholders in the community.

C. PROJECT MANAGEMENT (10 Points)

- **$** Qualifications and experience of key staff;
- **$** Staffing plans; cultural competence of staff;
- **$** Qualifications, experience, and capabilities of organizations for initiating and sustaining collaboration;
- **$** Qualifications, experience, and capabilities of collaborative organizations for implementing youth service programs;
- **$** Capabilities and project experience of key collaborating organizations;
- **$** Adequacy and feasibility of the project management plan including time lines and staffing patterns; and
- C Plan to sustain the service programs after the end of the project period.

## SECTION V - SPECIAL CONSIDERATIONS/REQUIREMENTS

SAMHSA:s policies and special considerations/requirements related to this program include:

- SAMHSA:s Inclusion Policy
- Government Performance Monitoring
- Healthy People 2010. The relevant sections of Healthy People 2010 Objectives that apply to this program are included in Chapters 7, 15, and 18.
- Consumer Bill of Rights
- Promoting Nonuse of Tobacco
- Supplantation of Existing Funds
- Letter of Intent
- Coordination with Other Federal/Non-Federal Programs:

  Applicants seeking support under this GFA are encouraged to coordinate with other programs when such coordination could enhance or expand service, evaluation, and/or knowledge development and dissemination of the proposed project, (e.g., the Center for Substance Abuse Prevention:s (CSAP) current announcement, entitled, **COOPERATIVE AGREEMENT FOR PARENTING AND FAMILY STRENGTHENING PREVENTION INTERVENTIONS: A DISSEMINATION OF INNOVATIONS INITIATIVE Short Title: FAMILY STRENGTHENING** (GFA) No. SP 00-002. You may find this CSAP program announcement via the Internet at http:www.samsha.gov.) In addition, applicants should be aware of the **COMMUNITY PREVENTION GRANT PROGRAM** (GFA SM00-004) which supports similar activities; however, the Community Prevention Grants offer support exclusively to States, Tribes, and their political subdivisions. Evidence of coordination with other agencies and funding sources would be especially important where such entities are presumed to be the source of direct service funding of the exemplary practice. Applicants should identify the coordinating organizations by name and address and describe the process that will be used to coordinate efforts. Federal and/or non-Federal organizations that agree to work/collaborate with the applicant are required to provide letters of formal commitment that specify the kind of work they will do and levels of support/resources they are prepared to make available to the applicant. These letters should be included in Appendix No. 1 entitled, "Documentation of Support and Commitment."
- Single State Agency Coordination
- Intergovernmental Review (E.O. 12372)
- Public Health System Reporting Requirements
- Confidentiality/SAMHSA Participant Protection.

Specific guidance and requirements for the application related to these policies and special considerations/requirements can be found in Part II in the section by the same name.

## SECTION VI - APPLICATION PROCEDURES

All applicants must use application form PHS 5161-1 (Rev. 6/99), which contains Standard Form 424 (face page). The following must be typed in Item Number 10 on the face page of the application form:

GFA No. SM00-005 Youth Violence Prevention Cooperative Agreement

In addition if the application is in response to suicide prevention this should be indicated as:

Suicide Prevention Priority

For more specific information on where to obtain application materials and guidelines, see the Application Procedures section in Part II. Completed applications must be sent to the following address.

SAMHSA Programs
Center for Scientific Review
National Institutes of Health
Suite 1040
6701 Rockledge Drive MSC-7710
Bethesda, MD 20892-7710*

*Applicants who wish to use express mail or courier service should change the zip code to 20817

Complete application kits for this program may be obtained from the Knowledge Exchange Network (KEN), phone number: 800-789-2647. The address for KEN is provided in Part II.

## APPLICATION RECEIPT AND REVIEW SCHEDULE

The schedule for receipt and review of applications under this GFA is as follows:

| Receipt Date | IRG Review | Council Review | Earliest Start Date |
|---|---|---|---|
| May 23, 2000 | June 2000 | September 2000 | September 2000 |

Applications must be received by the above receipt date(s) to be accepted for review. An application received after the deadline may be acceptable if it carries a legible proof-of-mailing date assigned by the carrier and the proof-of-mailing date is not later than 1 week prior to the deadline date. Private metered postmarks are not acceptable as proof of timely mailing. (NOTE: These instructions replace the "Late Applications" instructions found in the PHS 5161-1.)

## CONSEQUENCES OF LATE SUBMISSION

Applications received after the above receipt date will not be accepted and will be returned to the applicant without review.

## APPLICATION REQUIREMENTS/CHECK LIST

All applicants must use the Public Health Service (PHS) Grant Application form 5161-1 (Rev. 6/99) and follow the requirements and guidelines for developing an application presented in Part I Programmatic Guidance and Part II General Policies and Procedure Applicable to all SAMHSA GFA Documents.

The application should provide a comprehensive framework and description of all aspects of the proposed project. It should be written in a manner that is self-explanatory to reviewers unfamiliar with the prior related activities of the applicant. It should be succinct and well organized, should use section labels that match those provided in the table of contents for the Program Narrative that follows, and must contain all the information necessary for reviewers to understand the proposed project.

To ensure that sufficient information is included for the technical merit review of the application, the Programmatic Narrative section of application must address, but is not limited to, issues raised in the sections of this document entitled:

1. Program Description
2. Project Requirements
3. Guidelines and Review Criteria for Applicant

**Note: It is requested that on a separate sheet of paper the name, title, and organization affiliation of the individual who is primarily responsible for writing the application be provided. Providing this information is voluntary and will in no way be used to influence the acceptance or review of the application. When submitting the information, please insert the completed sheet behind the application face page.**

A **COMPLETE** application consists of the following components **IN THE ORDER SPECIFIED BELOW**. A description of each of these components can be found in Part II.

_____FACE PAGE FOR THE PHS 5161-1 (Standard Form 424 - See Appendix A in Part II for instructions.)

_____OPTIONAL INFORMATION ON APPLICATION WRITER (See note above)

_____ABSTRACT (not to exceed 30 lines)

_____TABLE OF CONTENTS (include page numbers for each of the major sections of the Program Narrative, as well as for each appendix)

_____BUDGET FORM (Standard Form 424A - See Appendix B in Part II for instructions.)

_____PROGRAM NARRATIVE (The information requested for sections A-C of the Program Narrative is discussed in the subsections with the same titles in Section II - Program Description, Section III Project Requirements, and Section IV - Guidelines and Review Criteria for Applicant. **Sections A-C may not exceed 25 single-spaced pages. Applications exceeding these page limits will not be accepted for review and will be returned to the applicant.**)

_____A. Project Description with Supporting Documentation

_____B. Project Plan: Goals, Target Population, Design, Methodology/Evaluation, Data Collection, and Analyses

_____C. Project Management: Implementation Plan, Organization, Staff, Equipment/Facilities, Budget, and Other Support

**There are no page limits for the following sections D-G except as noted in F. Biographical Sketches/Job Descriptions. Sections D-G will not be counted toward the <u>25 page limitation</u> for sections A-C.**

_____D. Literature Citations (This section must contain complete citations, including titles and all authors, for literature cited in the application.)

_____E. Budget Justification/Existing Resources/Other Support

_____Sections B, C, and E of the Standard Form 424A must be filled out according the instructions in Part II, Appendix B.

_____A line item budget and specific justification in narrative form for the first project year=s direct costs AND for each future year must be provided. For contractual costs, provide a similar yearly breakdown and justification for ALL costs (including overhead or indirect costs.

_____All other resources needed to accomplish the project for the life of the grant (e.g., staff, funds, equipment, office space) and evidence that the project will have access to these, either through the grant or, as appropriate, through other resources, must be specified.

<u>Other Support</u> (AOther Support@ refers to all current or pending support related to this application. Applicant organizations are reminded of the necessity to provide full and reliable information regarding "other support," i.e., all Federal and non-Federal active or pending support. Applicants should be cognizant that serious consequences could result if failure to provide complete and accurate information is construed as misleading to the PHS and could, therefore, lead to delay in the processing of the application. In signing the face page of the application, the authorized representative of the applicant organization certifies that the application information is accurate and complete.

For your organization and key organizations that are collaborating with you in this proposed project, list all currently active support and any applications/proposals pending review or funding that relate to the project. If there are none, state "none." For all active and pending support listed, also provide the following information:

1. Source of support (including identifying number and title).
2. Dates of entire project period.
3. Annual direct costs supported/requested.
4. Brief description of the project.
5. Whether project overlaps, duplicates, or is being supplemented by the present application; delineate and justify the nature and extent of any programmatic and/or budgetary overlaps.

F. Biographical Sketches/Job Descriptions

A biographical sketch must be included for the project director and for other key positions. Each of the biographical sketches must not exceed **2 pages** in length. In the event that a biographical sketch is included for an individual not yet hired, a letter of commitment from that person must be included with his/her biographical sketch. Job descriptions for key personnel must not exceed **1 page** in length. The suggested contents for biographical sketches and job descriptions are listed in Item 6 in the Program Narrative section of the PHS 5161-1.

G. Confidentiality/SAMHSA Participant Protection

The information provided in this section will be used to determine whether the level of protection of participants appears adequate or whether further provisions are needed, according to SAMHSA Participant Protection (SPP) standards Adequate protection of participants is an essential part of an application and will be considered in funding decisions.

Projects proposed under this announcement may expose participants to risks in as many ways as projects can differ from each other. Following are some examples, but they do not exhaust the possibilities. Applicants should report in this section any foreseeable risks for project

participants, and the procedures developed to protect participants from those risks, as set forth below. Applicants should discuss how each element will be addressed, or why it does not apply to the project.

Note: So that the adequacy of plans to address protection of participants, confidentiality, and other ethical concerns can be evaluated, the information requested below, which may appear in other sections of the narrative, should be included in this section of the application as well.

1. Protection from Potential Risks:

   (a) Identify and describe any foreseeable physical, medical, psychological, social, legal, or other risks or adverse effects, besides the confidentiality issues addressed below, which are due either to participation in the project itself, or to the evaluation activities.

   (b) Where appropriate, describe alternative treatments and procedures that might be advantageous to the subjects and the rationale for their nonuse.

   (c) Describe the procedures that will be followed to minimize or protect participants against potential risks, including risks to confidentiality.

   (d) Where appropriate, specify plans to provide needed professional intervention in the event of adverse effects to participants.

2. Equitable selection of participants:

   Target population(s):

   Describe the sociodemographic characteristics of the target population(s) for the proposed project, including age, gender, racial/ethnic composition, and other distinguishing characteristics (e.g., homeless youth, foster children, children of substance abusers, pregnant women, institutionalized individuals, or other special population groups).

Recruitment and Selection:

(a) Specify the criteria for inclusion or exclusion of participants and explain the rationale for these criteria.

(b) Explain the rationale for the use of special classes of subjects, such a pregnant women, children, institutionalized mentally disabled, prisoners, or others who are likely to be vulnerable.

(c) Summarize the recruitment and selection procedures, including the circumstances under which participation will be sought and who will seek it.

3. Absence of Coercion:

(a) Explain whether participation in the project is voluntary or mandatory. Identify any potentially coercive elements that may be present (e.g., court orders mandating individuals to participate in a particular intervention or treatment program).

(b) If participants are paid or awarded gifts for involvement, explain the remuneration process.

(c) Clarify how it will be explained to volunteer participants that their involvement in the study is not related to services and the remuneration will be given even if they do not complete the study.

4. Appropriate Data Collection:

(a) Identify from whom data will be collected (e.g., participants themselves, family members, teachers, others) and by what means or sources (e.g., school records, personal interviews, written questionnaires, psychological assessment instruments, observation).

(b) Identify the form of specimens (e.g., urine, blood), records, or data. Indicate whether the material or data will be obtained specifically for evaluative/research purposes or whether use will be made of existing specimens, records, or data. Also,

where appropriate, describe the provisions for monitoring the data to ensure the safety of subjects.

(c) Provide, in Appendix No. 5, entitled "Data Collection Instruments/Interview Protocols," copies of all available data collection instruments and interview protocols that will be used or proposed to be used in the case of cooperative agreements.

5. Privacy and Confidentiality:

Specify the procedures that will be implemented to ensure privacy and confidentiality, including by whom and how data will be collected, procedures for administration of data collection instruments, where data will be stored, who will/will not have access to information, and how the identity of participants will be safeguarded (e.g., through the use of a coding system on data records; limiting access to records; storing identifiers separately from data).

Note: If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse client records in accordance with the provisions of Title 42 of the Code of Federal Regulations, Part 2 (42 CFR, Part 2).

6. Adequate Consent Procedures:

(a) Specify what information will be provided to participants regarding the nature and purpose of their participation; the voluntary nature of their participation; their right to withdraw from the project at any time, without prejudice; anticipated use of data; procedures for maintaining confidentiality of the data; potential risks; and procedures that will be implemented to protect participants against these risks.

(b) Explain how consent will be appropriately secured for youth, elderly, low literacy and/or for those who English is not their first language.

Note: If the project poses potential physical, medical, psychological, legal, social, or other risks, awardees may be required to obtain written informed consent.

(c) Indicate whether it is planned to obtain informed consent from participants and/or their parents or legal guardians, and describe the method of documenting consent. For example: Are consent forms read to individuals? Are prospective participants questioned to ensure they understand the forms? Are they given copies of what they sign?

Copies of sample (blank) consent forms should be included in Appendix No.6, entitled "Sample Consent Forms." If appropriate, provide English translations.

Note: In obtaining consent, no wording should be used that implies that the participant waives or appears to waive any legal rights, is not free to terminate involvement with the project, or releases the institution or its agents from liability for negligence.

(d) Indicate whether separate consents will be obtained for different stages or aspects of the project, and whether consent for the collection of evaluative data will be required for participation in the project itself. For example, will separate consent be obtained for the collection of evaluation data in addition to the consent obtained for participation in the intervention, treatment, or services project itself? Will individuals not consenting to the collection of individually identifiable data for evaluative purposes be permitted to participate in the project?

7. Risk/Benefit Discussion:

Discuss why the risks to subjects are reasonable in relation to the anticipated benefits to subjects and in relation to the importance of the knowledge that may reasonably be expected to result.

_____APPENDICES (Only the appendices specified below may be included in the application. **These appendices must not be**

**used to extend or replace any of the required sections of the Program Narrative.** The total number of pages in the appendices **CANNOT EXCEED 30 PAGES,** excluding all instruments.)

_____Appendix 1: Eligibility Certification Documents . . .

_____Appendix 2: Letters of Coordination/~~Support~~. . . . .

_____Appendix 3: Copy of Letter(s) to SSA(s) . . . . . .

_____Appendix 4: Organizational Structure/Timeline/Staffing Patterns. .

_____Appendix 5: Data Collection Instruments/Interview Protocols..... . . . . .

_____Appendix 6: Sample Consent Forms . . . . . .

_____ASSURANCES NON-CONSTRUCTION PROGRAMS (STANDARD FORM 424B)

_____CERTIFICATIONS

_____DISCLOSURE OF LOBBYING ACTIVITIES

_____CHECKLIST PAGE (See Appendix C in Part II for instructions)

## TERMS AND CONDITIONS OF SUPPORT

For specific guidelines on terms and conditions of support, allowable items of expenditure and alterations and renovations, applicants must refer to the sections in Part II by the same names. In addition, in accepting the award the Grantee agrees to provide SAMHSA with GPRA Client Outcome and Evaluation Data.

Reporting Requirements

For the SAMHSA policy and requirements related to reporting, applicants must refer to the Reporting Requirements section in Part II.

Lobbying Prohibitions

SAMHSA's policy on lobbying prohibitions is applicable to this program.

## AWARD DECISION CRITERIA

Applications will be considered for funding on the basis of their overall technical merit as determined through the IRG and the CMHS National Advisory Council review process. Given the low number of applications from AAPI and Native American groups in the previous iteration of this grant announcement, an emphasis will be given to funding those applications that successfully meet the review criteria and provide for the overall balance across the program.

Other award criteria will include:

- Availability of funds and Overall program balance in terms of geography (including rural/urban areas), race/ethnicity of proposed project population, and project size, and mix of evidence-based programs.

## CONTACTS FOR ADDITIONAL INFORMATION

Questions concerning program issues on youth violence prevention may be directed to:

Tiffany Ho, M.D., Program Director
Division of Program Development, Special Populations and Projects
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Room 17C-26
Rockville, MD 20857
(301) 443-2892
(301) 443-5479 (FAX)
E-mail: tho@samhsa.gov

OR

Malcolm Gordon, Ph.D.
Special Programs Development Branch
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Room 17C-05
Rockville, MD 20857
(301) 443-2957
(301) 443-7912 (FAX)
E-mail: mgordon@samhsa.gov

Questions concerning program issues on youth suicide prevention may be directed to:

Robert DeMartino, M.D.
Associate Director for Program in Trauma and Terrorism
Center for Mental Health Services
US Public Health Service
5600 Fishers Lane, Room 17C-26
Rockville, MD 20857
(301) 443-2940
(301) 443-5479 (FAX)
e-mail: rdemarti@samhsa.gov

Questions regarding grants management issues may be directed to:

Stephen J. Hudak
Division of Grants Management, OPS

Substance Abuse and Mental Health Services Administration
Room 15-C-05
5600 Fishers Lane
Rockville, MD 20857
(301) 443-4456
FAX: (301) 594-2336
Email: shudak@samhsa.gov

## REFERENCES

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Huang, L.N. (2000) Prevention of youth violence in Asian American Pacific Islander communities: A social ecology perspective. Unpublished paper. Rockville, Maryland: SAMHSA (CMHS).

Kellam, S. G., Mayer, L. S., Rebok, G. W., and Hawkins, W. E. (1998) Effects of improving achievement on aggressive behavior and of improving aggressive behavior on achievement through two preventive interventions: An investigation of causal paths. In, Bruce P. Dohrenwend, et al. (Eds.). Adversity, stress, and psychopathology. New York, NY: Oxford University Press, 486-505..

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Novins, D. K., Duclos, C. W., Martin, C., Jewett, C. S., and Manson, S. M. (1999) Utilization of alcohol, drug, and mental health treatment services among American Indian adolescent detainees. Journal of the American Academy of Child & Adolescent Psychiatry, 38, 1102-1108.

Office of Technology Assessment (1990) Indian Adolescent Mental Health. Washington, D.C.: U.S. Government Printing Office.

Serafica, F. C. (1999) Clinical interventions and prevention for Asian American children and families: Current status and needed research. Applied & Preventive Psychology. 8, 143-152.
Serafica, F. C. (1997) Psychopathology and resilience in Asian American children and adolescents. Applied Developmental Science, 1, 145-155.

Wilson-Brewer, R. and Jacklin, B. (1991) Violence prevention strategies targeted at the general population of minority youth. Public Health Reports, 106, 270-271.

Note: applicants wishing to obtain additional references and resources on 1) youth violence prevention/resilience enhancement programs, 2) community collaboration, and 3) evaluation may request them from Dr. Malcolm Gordon, 301-443-2957.

# APPENDIX A
# GPRA STRATEGY

OVERVIEW

The Government Performance and Results Act of 1993 (Public Law-103-62) requires all federal departments and agencies to develop strategic plans that specify what they will accomplish over a three to five year period, to annually set performance targets related to their strategic plan, and to annually report the degree to which the targets set in the previous year were met. In addition, agencies are expected to regularly conduct evaluations of their programs and to use the results of those evaluations to Aexplain@ their success and failures based on the performance monitoring data. While the language of the statute talks about separate Annual Performance Plans and Annual Performance Reports, ASMB/HHS has chosen to incorporate the elements of the annual reports into the annual President=s Budget and supporting documents. The following provides an overview of how the Office of the Administrator/SAMHSA, CMHS, CSAT, and CSAP, are addressing these statutory requirements.

**DEFINITIONS**

| | |
|---|---|
| Performance Monitoring | The ongoing measurement and reporting of program accomplishments, particularly progress towards preestablished goals. The monitoring can involve process, output, and outcome measures. |
| Evaluation | Individual systematic studies conducted periodically or Aas needed@ to assess how well a program is working and why particular outcomes have (or have not) been achieved. |
| Program | For GPRA reporting purposes, a set of activities that have a common purpose and for which targets can (will) be established.[2] |

[2]GPRA gives agencies broad discretion with respect to how its statutory programs are aggregated or disaggregated for GPRA reporting purposes.

| | |
|---|---|
| Activity | A group of grants, cooperative agreements, and contracts that together are directed toward a common objective. |
| Project | An individual grant, cooperative agreement, or contract. |

**CENTER (OR MISSION) GPRA OUTCOMES**

The mission of the Center for Mental Health Services (CMHS) is to improve the quality and availability of mental health services. Working in partnership with governmental agencies at Federal, State, and local levels, as well as professional and community based organizations, CMHS activities are designed to improve access and reduce barriers to high quality services for people with, or at risk for, mental illnesses and disorders.

**APROGRAMS@ FOR GPRA REPORTING PURPOSES**

All activities in SAMHSA have been divided into four broad areas or Aprogrammatic goals@ for GPRA reporting purposes:

- Goal 1: Assure services availability;
- Goal 2: Meet unmet and emerging needs;
- Goal 3: Bridge the gap between research and practice;
- Goal 4: and Enhance service system performance[3]

1. **ASSURE SERVICES AVAILABILITY**

More specifically:

- Number of adults receiving services who:
  - (a) were currently employed or engaged in productive activities;
  - (b) had a permanent place to live in the community;
  - (c) had no/reduced involvement with the criminal justice system.

d) had no past month use of alcohol or illegal drugs

- Number of children and youth receiving services who:
  - a) were attending school
  - b) were residing in a stable living environment
  - c) had no involvement in the juvenile justice system
  - d) had no past month use of alcohol or illegal drugs

In addition, customer satisfaction with Technical Assistance, Needs Assessment Services provided to grantees and direct services for consumers may be utilized for reporting.

2. **MEET UNMET OR EMERGING NEEDS**

Simplistically, the following questions need to be answered about these activities within a performance monitoring context:

- Were identified needs met?
- Was service availability improved?
- Are client outcomes good (e.g., better than benchmarks)?

The strategy, developed and shared by the three Centers, involves requiring each SAMHSA project that involves services to individuals to collect a uniform set of data elements from each individual at admission to services and 6 and 12 months after admission. The outcomes (as appropriate) that will be tracked using this data are:

- Percent of adults receiving services increased who:
  a) were currently employed or engaged in productive activities
  b) had a permanent place to live in the community
  c) had reduced involvement with the criminal justice system
  d) had no past month use of illegal drugs or misuse of prescription drugs

- Percent of children/adolescents under age 18 receiving services who:
  a) were attending school
  b) were residing in a stable living environment
  c) had no involvement in the juvenile justice system
  d) had no past month use of alcohol or illegal drugs

3. **BRIDGE THE GAP BETWEEN RESEARCH AND PRACTICE**

This Aprogram@ or goal covers that set of activities that are knowledge development/research activities.

The purpose of conducting knowledge development activities is to provide answers to policy-relevant questions or develop cost-effective approaches to organizing or providing services that can be used by the field. Simplistically then, there are two criteria of success for knowledge development activities:

- Knowledge was developed; and
- The knowledge is potentially useful to the field.

While progress toward these goals can be monitored during the conduct of the activity, only after the data are collected, analyzed, and reported can judgments about success be made.

4. **ENHANCE SERVICE SYSTEM PERFORMANCE**

Ultimately, the increased use of efficient and effective practices should increase the availability of services and effectiveness of the system in general. However, measures of treatment availability and effectiveness are not currently available. Within existing resources, it would not be feasible to consider developing a system of performance measurement for this purpose.

**EVALUATIONS**

As defined earlier, evaluation refers to periodic efforts to validate performance monitoring data; to examine, in greater depth, the reasons why particular performance measures are changing (positively or negatively); and to address specific questions posed by program managers about their programs. These types of evaluation are explicitly described, and expected, within the GPRA framework. In fact, on an annual basis, the results of evaluations are to be presented and future evaluations described.

# APPENDIX B
# SUICIDE PREVENTION

## BACKGROUND

In 1997, suicide was the third leading cause of death for persons aged 10 to 24. Increases in youth suicide completion rates over the past few decades, and annual survey data that indicate that up to 7 percent of high school youth have attempted suicide, have prompted a number of calls by public health officials to improve efforts to prevent and treat suicidal behaviors in youth. Most recently, the Office of the Surgeon General issued a ACall to Action to Prevent Suicide@ [see http://www.sg.gov/library/calltoaction/default.htm]. This call recognizes the advances in understanding the potential precursors and risk factors for youth suicidal behavior, specifically mental and substance use disorders (SUD includes both substance dependence and substance abuse). Increased knowledge about precursors for completed adolescent suicides has come from several controlled psychological autopsies. For adolescent males, comorbid conduct disorder, mood disorder and SUD are among the most common diagnoses. For adolescent females, mood disorders predominant, with lower rates of comorbid SUD and conduct disorder compared to male suicide decedents. Epidemiologic studies of suicidal youth have also identified co-occurring mood disorders, SUD, and stressful life events as risk factors for suicidal behaviors.

Certain subpopulations of youth are known to have greater risk for suicidal behavior. American Indian and Alaskan Native male youth have suicide rates that are ten times the U.S. average. However, there is substantial variation in suicide rates and various risk factors, such as SUD, by tribe. African American male youth had historically low suicide rates. However, between 1980 and 1996 their rates doubled, approximating the rates of their white counterparts. Recent school shootings and subsequent suicidal behavior by perpetrators have resulted in the U.S. Department of Education assisting schools to prepare for crisis situations, including early identification of behaviors or Awarning signs@ among youth at risk [see http://www.ed.gov/offices/OSERS/OSEP/earlywrn.html]. Many of the early warning signs for later violent behavior have also been found to be correlates and precursors of suicidal behavior. Runaway and homeless youth, for instance, are at greater risk for suicidal behavior relative to their counterparts who attend school.

## THE ISSUE OF PREVENTION

### Defining three general classes of prevention strategies:

**"Universal"** prevention strategies are targeted at the entire population. This blanket approach increases the likelihood that all at-risk persons will be "inoculated" by the prevention activity, but on a mass level it is difficult to control how much "prevention dose" each subject receives. The mass approach may also be more expensive than the alternatives. Any prevention strategy should clearly outweigh the costs and risks of implementing that strategy. This requirement is true for all three types of prevention strategies, but the burden of showing this positive balance is greatest for the "universal" group, because the costs are often high and the risks are often ignored.

**"Selective"** prevention strategies are targeted at specific subgroups who are known or thought to be at elevated risk for suicidal behavior. "Selective" strategies tend to address the risk factor(s) defining the subgroup at risk, directly or indirectly. A direct strategy might involve intervening to lower depression severity for a subgroup of youth who qualified for a diagnosis of major depression. An indirect strategy might involve offering support and education to a gay/lesbian/bisexual youth who was thought to be at risk by virtue of his/her sexual orientation and/or the environmental response to his lifestyle.

An integrated community plan that incorporates a variety of approaches to prevention might include developing a local suicide attempt surveillance system; creating specific intervention programs for identified suicide attempters; teaching gatekeepers, such as school personnel, counselors, coaches, family members, friends, youth group leaders, how to identify those at high risk of suicide; restricting lethal means of suicide, especially for newly incarcerated prisoners and potentially suicidal adolescents; increasing access to suicide prevention services; and integrating suicide prevention into programs focused on preventing antecedent risk factors for suicide, such as depression, substance abuse, and delinquency (O'Carroll, Kravitz & Clark 1990). Shaffer et al (1988) suggest that introducing mental health services into a community should reduce the suicide rate by reducing the burden of mental illness.

**"Indicated"** prevention strategies are targeted at individuals known or suspected to be at high risk for suicide. This approach presumes that tools exist for identifying individuals at high risk with good sensitivity and specificity (i.e., not many "false positive" or "false negatives").

The school is but one logical and natural site for instituting preventive models to address public health problems of youth: student attention is held relatively captive, teaching and learning are normative tasks, and peer interaction can be mobilized around a common theme (Berman and Jobes, Kravitz & Clark 1991:Ch.6). School-based programs are the most efficient means for reaching the greatest number of at-risk adolescents (Mazza, 1997). However, it has yet to be established that the focus of changing attitudes and knowledge and the attempt to impart skill building in relatively short periods of training can impact on the ultimate goal of these models -- decreasing the incidence of suicidal behavior (Berman and Jobes, 1991:Ch.6,p.235).

Suicide prevention and crisis intervention programs to date have fostered a mentality that not much can be done about suicide until a person either talks about or engages in suicidal behavior Individual interventions have been the foundation of most suicide prevention programs, yet it is preferable for prevention programs to move toward multifaceted approaches that include numerous interventions and multiple segments of the community (Potter et al, 1995).

**THE ISSUE OF RISK**

Intervention programs prevent suicide by reducing or eliminating risk factors for suicide and promoting protective factors. This risk and protective factor approach is the foundation for any organized community plan for preventing suicide. Risk factors are not necessarily warning signs for suicide. **Risk factors** with an empirical basis include:

- Mental disorders, especially mood disorders, schizophrenia, substance use disorders, and borderline personality disorder. Persons with more than one disorder have greatly elevated risk.
- Previous suicide attempt, with risk increasing as the number of attempts increases
- Family history of suicide, both from the genetic predisposition and influence of example
- Impulsive and/or aggressive tendencies

_ Dangerous feeling states when suicidal ideas are present, especially hopelessness, agitated restlessness, intoxication or withdrawal, cognitive restriction, and impaired reality testing
_ Physical illnesses that have direct brain effects
_ Social, financial, relational, or occupational loss
_ Easy access to lethal methods
_ Social isolation and lack of rapport with others
_ Contagious influence of celebrated suicides or local clusters of suicide

**Protective factors include:**
_ Family and community support
_ Restricted access to highly lethal or enticing methods of suicide
_ Active skills in problem solving, conflict resolution, self-esteem regulation, and nonviolent handling of disputes
_ Effective treatment and relapse prevention for underlying mental and substance use disorders
_ Easy access to a variety of clinical interventions and support for help seeking
_ Cultural and religious beliefs that discourage suicide and violence and support self-preservation instincts

Prevention efforts that address generic risk and protective factors early before dysfunctional behavior occurs are more effective. Since generic risk and protective factors for suicide affect functioning across many domains, prevention components should coordinate action across multiple domains, such as the family, the individual, schools, the community, and the health care system. Planning for this type of prevention requires collaboration across many disciplines and sectors of society: government, health, education, human services, religion, voluntary organizations, and business.

**THE ISSUE OF EFFECTIVE PROGRAMS**

Any critical review of the scientific literature and "best practices" reveals two major handicaps facing all who design, test, or implement youth suicide prevention programs. There is a dearth of empirical suicide prevention trials, and there is a dearth of empirical suicide treatment trials to guide our planning. These problems are not unique to the field of youth suicide prevention. The same can be said about the status of knowledge about suicide prevention and treatment for all other age groups.

It is unlikely that any single, universally effective intervention will solve the complex problem of youth suicide. In assuming that all high risk behaviors are interrelated, Silverman and Felner (1995, in S&McD,1996:Ch.8) summarized the following approach as common to effective suicide programs: developing an integrated package of services and programs within each community; developing strategies focused on changing institutions such as schools and the welfare system rather than changing individuals; implementing the programs before a crisis presents itself; and maintaining the program over a long period.

The CDC in 1992 published Youth Suicide Prevention Programs: A Resource Guide (http://aepo-xdv-www.epo.cdc.gov/wonder/prevguid/p0000024/entire.htm) which describes the rationale and evidence for the effectiveness of eight strategies to prevent youth suicide and identifies model programs in North America that incorporate them. This guide, a review of first generation prevention programs, was developed using input from suicide prevention experts in the U.S. and Canada, who identified and described programs that they judged to be likely to be effective. Representatives from these "exemplary" youth suicide prevention programs were then surveyed about their program. Eight types of preventive strategies were delineated, including: (1) school gatekeeper training, (2) community gatekeeper training, (3) general suicide education, (4) screening programs, (5) peer support programs, (6) crisis centers and hotlines, (7) means restriction, and (8) intervention after a suicide (postvention).

Several general recommendations were made in the guide:

XV: Suicide prevention programs should be linked as closely as possible with professional mental health resources in the community.

XVI: Communities should not rely on only one prevention strategy; certain strategies tended to predominate among prevention efforts despite limited evidence for effectiveness, leading to the recommendation to incorporate into current programs when possible promising but underused strategies.

XVII: Expansion of suicide preventive efforts for young adults aged 20-24 years and other age groups with suicide rates that are higher than those in adolescents and teenagers in school;

a disproportionately larger percentage of prevention efforts have been directed toward the latter.

XVIII: Incorporate evaluation into new and existing suicide prevention programs when practical, including measures of, or closely associated with the incidence of suicidal behavior. This is a major concern: there is insufficient scientifically based, quantitative information for making decisions about where to spend precious resources.

The eight strategies found in this first generation of suicide prevention programs listed in the CDC's guide were critically reviewed by Berman and Jobes (1995) and by Potter et al (1995). Overall, Potter et al (1995) commented that most programs "embrace the high-risk model of prevention, in which the goal is case finding and referral" (e.g., screening and referral and crisis centers). Berman and Jobes (1995) commented that the eight strategies represented just two conceptual strategies: (1) recognition and referral, and (2) risk factor counteraction. Neither of these two intervention approaches could be evaluated as more effective than the other due to insufficient current scientific information about the efficacy of suicide prevention strategies (Potter et al, 1995). The programs were criticized as inadequate in: (1) linkages to both other community resources and risk prevention programs, (2) focusing means restriction and/or other promising preventive efforts, (3) evaluation research, particularly focusing on preventive outcomes and iatrogenic effects, and (4) primary prevention models focused on the high- risk individual (Berman and Jobes, 1995). Also, interventions directed toward the general population (e.g., suicide awareness or education, media guidelines, means restrictions) were rare (Potter et al, 1995).

Berman and Jobes (1995) compiled a brief summary of the initial evaluations of these eight strategies. Initial evaluations of <u>school gatekeeper training</u> documented both satisfaction and learning gains, but behavioral outcomes were not documented. Initial evaluations of <u>community gatekeeper training</u> did not focus on changes in desired behaviors among those given this training. Evaluations of <u>general suicide education</u> only demonstrated short-term gains in knowledge and increased recognition of referral sources; attitudes toward seeking help generally have not been affected by these programs and changes in behavior were not formally evaluated. <u>Screening programs</u> (early detection and referral, secondary prevention) were evaluated as "in a developmental stage, with

significant problems in scale construction;" triage problems also had not been resolved as well as problems with misclassification for referral to treatment (both false negatives and false positives). Peer support program evaluations suggested that they may be able to reduce high-risk behaviors, but the link to preventing suicide remains to be empirically established. Evidence for the effectiveness of crisis centers and hotlines is inconsistent and they may be less effective in reducing overall suicide rates because at-risk young males may not be socialized to seek help or to communicate to a hotline their suicidality. Means restrictions, particularly geared reducing access to firearms, is supported by naturalistic data, but needs to be studied in a more widespread and purposeful implementation in a carefully designed and well-evaluated program to prevent youth suicide. Postvention and cluster prevention interventions have been implemented in senior high schools as part of an overall crisis response team approach to a variety of potential school and community traumata (CDC, 1988 in MMWR suppl).

*School-Based Programs*

Is there any evidence school-based youth suicide prevention programs are effective? Do good intentions and professional input guarantee that the programs are safe? Since the great majority of adolescents never make a suicide attempt in their entire lifetime, can existing suicide prevention programs educate the low-risk majority and "inoculate" the high-risk minority in one fell swoop?

Garland and colleagues (1989) examined survey response data characterizing 115 youth suicide prevention programs identified in 34 states that had been in place for five years. The typical program reached 17 schools encompassing 1700 students during the 1986-87 school year. Forty-four percent of the programs were offered to children from elementary school all the way through high school; 98% were offered to high school students. Eighty-nine percent offered some form of training or education to school staff, and 71% included a program for parents. While most of the programs spent only one hour of direct contact time with students, 34% spent more than two hours. Most programs covered facts about suicide, warning signs of suicide, mental health resources available to the students, and techniques for getting a troubled student in touch with help. The great majority of program (95%) reported that their theoretical approach was patterned after the "stress model," wherein "suicide is seen as a response to extreme stress, to which everyone is vulnerable." Only four

percent subscribed to the view that suicide is typically a consequence of a mental disorder. The investigators warned that the prevailing assumptions (all youth are at risk for suicide and suicide is a result of overwhelming stress) are not supported well by available scientific evidence. Suicide rarely occurs in the absence of a documentable psychiatric illness.

In 1997 Mazza conducted an extensive review on the effectiveness of eleven school-based suicide prevention programs. The principal goals of the reviewed programs were suicidal behavior education and identification of peers who may be at risk for suicide. Mazza believes that the prevention programs may have shown limited effectiveness because they targeted all students regardless of their previous behavior or current risk status rather than directing efforts toward those most at-risk for suicide. Furthermore, there is particular concern because several reports, cited in Mazza, have documented that adolescents who were at the greatest risk for future suicidal behavior showed increased levels of hopelessness, more maladaptive coping strategies, and less evaluative skills after the prevention programs were implemented. The implication is that the content focus of school-based suicide education programs should be on the nature of major psychiatric disorders associated with a risk for suicidal behavior and ways to access appropriate quality mental health treatment, rather than a specialized focus on suicide thinking or behavior per se.

Garland and colleagues suggest that instead of continuing to devote so many resources to prevention programs that do not yet reach one percent of the U.S. high school population, it would be wiser to focus prevention efforts on youngsters known to be elevated risk for suicide: those struggling under the influence of mental disorder (e.g., major depression, alcohol or drug abuse, schizophrenia), those who have made suicide attempts before, and those recently exposed to a model of suicide. It is feasible to identify a large proportion of these high-risk individuals and tailor prevention efforts to their unique situations.

The authors conclude by recommending that school-based suicide prevention programs focus their efforts in three areas: (a) institute systematic psychological screening procedures to identify children and adolescents with symptoms including suicidal ideation; (b) teach children and adolescents how to recognize psychiatric symptoms in themselves; (c) change

attitudes by encouraging children and adolescents to be more receptive to the idea of seeking help from adults. Findings by Shaffer et al (1990) suggest that purely educational programs are not appropriate for identifying and reaching high-risk adolescents, show limited effectiveness in changing pathological attitudes among the small number of high-risk students who may be targeted by these programs, and may have untoward effects in not-at-risk students. Consistent with other data, these results suggested that techniques combining more efficient case identification of (treated or untreated) high-risk potential youth suicides with individualized evaluation and intervention would be the most beneficial (Blumenthal, 1990; Shaffer et al, 1990).

Zenere and Lazarus (1997) recently reported that a school district-wide suicide prevention and school crisis management program provided for five years to the fourth largest public school system in the United States (Dade County, Florida) had a positive influence on suicide death rates and suicide attempt rates over time. In the absence of any meaningful comparison group, however, it is difficult to accept the premise that the program had a direct impact on suicidal behavior. Other changes (e.g., accessibility or quality of health care, alcohol/drug use patterns) occurring in the county during the same period may account better or more directly for the decline in suicidal behavior.

A more recent review by Shaffer and Craft (1999) argues forcefully for the effectiveness of in-school self-administered screening programs. It involves systematic screening for the predictors of suicide in general high school populations. As a strategy for identifying teenagers at greatest risk for suicide, Shaffer writes that the careful employment of such a method would be both efficient and cost effective. The adoption of such a strategy would likely involve the use of in-school professionals and requires a robust relationship with community-based mental health and substance abuse services.

In view of the history of suicide prevention programs and the information available as to their effectiveness, certain approaches to preventing and treating youth suicidal behavior are suggested. And, while applications pertaining to the following topics are encouraged, these topics should be considered illustrative, and not restrictive.

- Programs designed specifically to screen for high risk youth (e.g. runaways, teens in substance abuse programs, school drop outs, youth with a history of prior sexual abuse, gay/lesbian/bisexual youth) for previous suicide attempts, coupled with current suicide ideation, depression or other specific risk factors (mental illness, substance abuse) and establish a referral and follow-up system

- Programs devising or applying curricula to assist teens to identify their own depressive disorders and to seek professional help.

- Programs providing the means for parents to detect and obtain treatment for mood disorders and other illness (e.g. substance abuse) in their children.

- Programs engaging community partners (parents, schools, etc) to ensure youth compliance with medical treatment efforts designed to reduce risk factors for suicide (e.g. mental illness, substance abuse)

- Programs that provide the means for primary care physicians to identify, treat and/or refer significant mood and substance use disorders in their youth patient population.

- Programs to plan and implement an advertising campaign to encourage teens at high risk for suicide (older males with mood and substance abuse disorders) to call specialized crisis intervention lines.

- Educational and advertizing programs to encourage depressed youth to refer themselves for treatment.